Program & Fiscal Information

Legislative Authority

In April 1973, the 63rd Texas Legislature passed the Kidney Health Care Act (Article 4477-20, VCS), later recodified under the Texas Health and Safety Code, Chapter 42. The Kidney Health Care Act established the Kidney Health Care Program under the Texas Department of Health. This law directs the use of State funds and resources to be used for the care and treatment of persons suffering from end-stage (chronic) kidney disease. In so doing, the Legislature recognized the State's "responsibility to allow its citizens to remain healthy without being pauperized . . ." by the extremely expensive treatment which is necessary for those suffering from this disease. This Annual Report is submitted in compliance with the Texas Health and Safety Code, Chapter 42, Section 16.

History

End-Stage Renal Disease (ESRD) is the complete cessation of kidney function which necessitates the use of some mode of renal replacement therapy to maintain bodily functions normally performed by the kidneys. Before 1973, persons suffering from ESRD had very few options available to them to treat this disease. Death was the most common outcome because few patients could afford the tremendous expense associated with the options of renal replacement therapy (dialysis treatment or kidney transplantation).

In 1973, Congress created the Chronic Renal Disease (CRD) Program under Medicare to assist ESRD patients with the financial burdens associated with this disease. Under the CRD Program, Medicare covers allowable medical costs for dialysis and transplant patients who are fully or currently insured under Social Security. This made treatment more accessible and has increased the number of ESRD patients receiving therapy.

Despite the Medicare CRD Program, the impact and cost of ESRD on Texans can be great. Most dialysis patients do not receive any medical benefits from Medicare for a three-month period after the initiation of dialysis, and Medicare does not offer any coverage for most drug and travel expenses associated with the treatment of ESRD. To help ease this burden on people suffering from this long-term chronic illness, the Texas Legislature created the Kidney Health Care Program (KHC). KHC became operational in September of 1973 under the administration of the Texas Department of Health. The primary purpose of KHC is to "direct the use of resources and to coordinate the efforts of the State in this vital matter of public health."

The Kidney Health Care Program has grown from 817 approved applicants in FY74, its first full year of operation, to **20,895** program recipients in FY99. During these twenty-six years of operation 59,842 residents with ESRD have received financial assistance for access surgery, dialysis treatments, hospitalization, medication, and transportation costs that are incurred in the treatment of ESRD.

Benefits available to qualified recipients have changed somewhat over the years, but have always included reimbursement for drugs, travel expenses, and medical services (see FY99 Benefits, page 3).

Fiscal Year 1999 Accomplishments

- Established a Policy Section to develop, review and revise KHC policies and procedures.
- Continued to increase the public's awareness and knowledge about kidney disease and organ donation by providing educational programs and participating in community health education programs.
- Implemented a new contract process for the 2000-2001 biennium by following the Texas Department of Health contract requirements and redesigning KHC contracts to reflect these requirements.
- Developed a New KHC Recipient Handbook for KHC recipients that provides an overview of the program benefits.
- Developed an addendum to the Vendor Drug Program Provider Manual to include KHC requirements.
- Distributed enrollment information and materials statewide to KHC pharmacies in preparation for KHC's consolidation of the drug claims processing function with the Vendor Drug Program.
- The KHC Customer Service Section approved 4,440 new applicants for benefits. In addition, 234 applicants were approved for reinstatement of benefits.
- As a result of Rider 38 of the Appropriations Act of the 75th Texas Legislature and House Bill 494 of the 76th legislative session, 150 drug manufacturers have signed voluntary rebate agreements with KHC. This allows KHC to receive a rebate for covered drugs and drug products that are paid by KHC and marketed by these companies.
- The implementation of Senate Bill 862 of the 76th Texas Legislature was assigned to the Bureau of Kidney Health Care. Senate Bill 862 calls for the establishment of a 13-member Task Force to examine current organ allocation policies in Texas. The Task Force members were appointed by the Commissioner of Health in July of 1999. The Bureau of Kidney Health Care will provide administrative support for the Task Force until December 2000.
- On July 23, 1999, the Texas Board of Health approved the revision of the Kidney Health Care Rules, which became effective on August 15, 1999. The rules changes were necessary to facilitate the consolidation of the KHC drug claims processing function with the Vendor Drug Program and to facilitate the implementation of KHC's new automated computer system (see KHC Rules Changes, page 4).

Fiscal Year 2000 Program Goals

Consistent with the Bureau's efforts to maintain continuous quality improvements, the following goals were developed for Fiscal Year 2000:

- Implement KHC's new automated eligibility and claims processing system (ASKIT) and fully integrate the system so that KHC

providers can electronically submit applications and claims on-line.

- Consolidate KHC's drug claims processing function with the Medicaid Vendor Drug Program.

- Continue to improve the services provided by the Customer Services section by assessing current levels of service delivery and analyzing factors such as accuracy, response time, and access to information.

- Continue to increase the public's awareness and knowledge about kidney disease and organ donation by providing educational programs and materials and participating in community education programs.

- Provide enhanced monthly and quarterly expenditure reporting information and provide projection reports utilizing forecasting software.

- Senate Bill 673 (Anatomical Gift Education Program) of the 76th Texas Legislature was assigned to the Bureau of Kidney Health Care. KHC will implement a program to educate Texans about anatomical gifts.

- Develop policies pertaining to the operation of KHC's new automated computer system, consolidation with Vendor Drug, and Rules and publish on the KHC web-site.

Program Eligibility

An applicant must meet all of the following requirements to receive Kidney Health Care benefits:

- Have a diagnosis of End Stage Renal Disease (ESRD);

- Be a resident of the State of Texas and provide documentation of Texas residency;

- Submit an application for benefits through a participating facility;

- Meet the Medicare criteria for ESRD; and

- Have an Adjusted Gross Income of less than $60,000 per year.

Specific benefits are dependent on the applicant's treatment status and eligibility for benefits from other programs such as Medicare, Medicaid, or private insurance. KHC benefits, which are subject to budget limitations, include payment for allowable drug, transportation, and medical expenses incurred as a direct result of ESRD treatment.

Fiscal Year 1999 Benefits

Drugs

This benefit is available to all recipients, except those receiving Medicaid unlimited prescription benefits (such as those under age twenty-one and participants in Managed Care Plans or community-based assistance programs). Reimbursement is limited to a $350 monthly maximum (does not include immunosuppressive drugs). Reimbursement is also limited to KHC allowable drugs. The KHC Advisory Committee and the Texas Department of Health Pharmacy Division recommend which drugs are to be covered by the program. A $1.00 co-pay is applied to each drug product paid for by the program. All KHC recipients are required to obtain their medications from a KHC participating pharmacy in order to be covered by the program.

Transportation

Travel reimbursement is limited to the recipient's actual cost or KHC's computed rates, whichever is less. Reimbursement is limited to a $200 monthly maximum. (Mileage rates may vary in response to budgetary constraints).

Medical

KHC provides limited payment for ESRD-related medical services. Allowable services are limited to inpatient and outpatient dialysis treatments and medical services required for access or transplant surgery, which include hospital, surgeon, and anesthesiology charges. Transplant surgery was discontinued as a benefit in August 1999 due to low utilization by program recipients and providers.

Medical services are provided to eligible recipients during the pre-Medicare period (normally a three month period following the initiation of chronic dialysis treatments), or to recipients who can document that they are not eligible for Medicare or Medicaid benefits. Reimbursement during the Medicare qualifying period cannot exceed $15,000 per recipient.

Access Surgery. Access surgery is a procedure necessary for the initiation of dialysis treatments. Charges for hospitilization, surgeon and assistant surgeon fees, as well as anesthesiologist fees are covered. Because this surgery is typically done prior to when the patient qualifies for ESRD benefits through Medicare or KHC, this benefit can be paid retroactively, up to 365 days before the KHC date of eligibility. Total reimbursement for each access surgery is limited to $4,100. (More information about access surgery benefits and limitations is available upon request from KHC).

Medicare Premium Payment

KHC will pay the premium for Medicare parts A and B on behalf of KHC recipients who are: 1) eligible to purchase this coverage according to Medicare's criteria; 2) not eligible for "premium free" Medicare part A (hospital) insurance under the Social Security Administration; and 3) not eligible for Medicaid payment of Medicare premiums.

The following limitations apply to KHC benefits:

- KHC benefits are paid only after all other third-party payors have met their liability.
- Claims must be received by KHC by the applicable filing deadlines. (Detailed filing deadline information is available upon request from KHC).
- KHC benefits are limited to recipients whose Adjusted Gross Income is less than $60,000 per year.
- Except for transplant surgery, payment of benefits is limited to $15,000 during the pre-Medicare period. This limitation includes all benefits paid to or on behalf of the recipient, including drugs, travel, and immunosuppressive drugs.
- All reimbursements are subject to a $30,000 maximum benefit per recipient, per fiscal year.

KHC Rules Changes Effective August 15, 1999

On July 23, 1999, the proposed changes to the Kidney Health Care rules were adopted by the Texas Board of Health and became effective on August 15, 1999. The rules changes were necessary to facilitate the consolidation of KHC's drug claims processing system with the Medicaid Vendor Drug Program's drug claims processing system and to facilitate the implementation of KHC's new automated patient and provider enrollment and medical/ transportation claims processing system. The following is a summary of important rules changes as they apply to KHC benefits.

Section 61.4 – Applications

- The eligibility effective date was changed from 90 days to 30 days prior to the date KHC receives a completed application or the first date of dialysis or date Texas residency is established, whichever is later.

Section 61.6 – Limitations and Benefits Provided

- Immunosuppressive Drugs (ISDs) are no longer considered a separate drug benefit.
- Transplant surgery is no longer a benefit payable by KHC.
- Recipients eligible for drug coverage under a private/group health insurance plan are not eligible to receive KHC drug benefits. A recipient who has exhausted drug coverage under a private/group health insurance plan may be eligible to receive drug benefits from KHC.
- Retroactive coverage of access surgery benefits was changed from 365 days to 180 days prior to the recipient's KHC eligibility date.

Recipient Adjusted Gross Income Distribution

Table 1 reports the adjusted gross income (AGI) distribution of FY99 KHC recipients. As in previous years, the largest percentage of benefits has been paid to those recipients who have an AGI of less than $20,000 annually.

Table 1: FY99 Recipient Adjusted Gross Income

Adjusted Gross Income	# of Recipients	% of Recipients
$ 0-19,999	14,214	83.2%
$ 20,000-29,999	1,535	9.0%
$ 30,000-39,999	754	4.4%
$ 40,000-44,999	236	1.4%
$ 45,000-49,999	148	0.9%
$ 50,000-54,999	128	0.7%
$ 55,000-59,999	76	0.4%
$ 60,000+	0	0.0%
	17,091*	100%

**As of August 31, 1999*

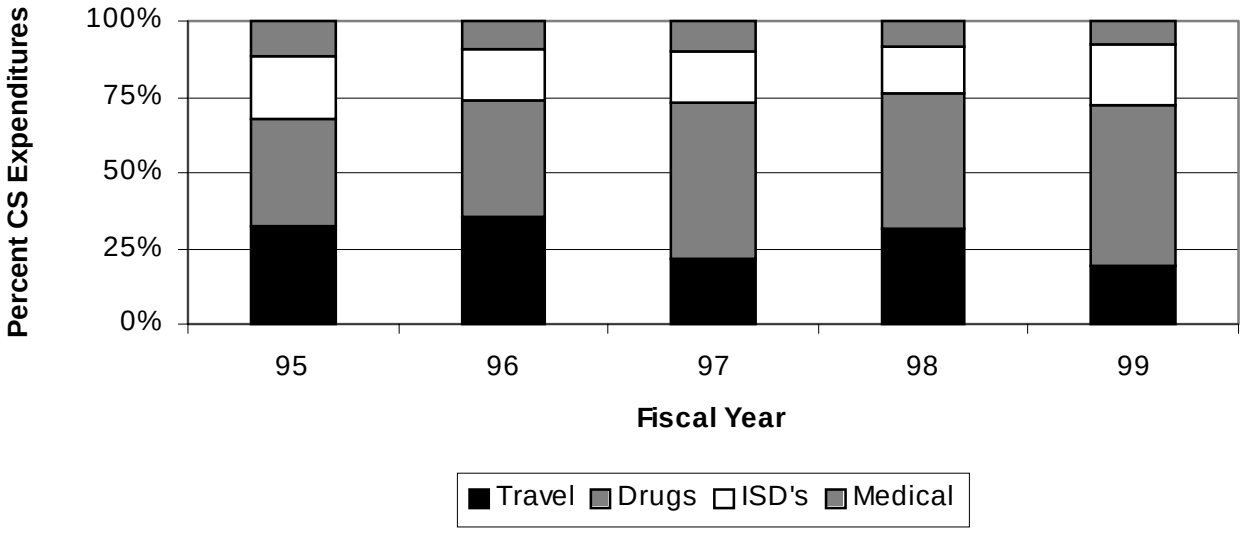
Fiscal Year 1999 Client Services Expenditures

Table 2 reports the distribution of client services expenditures provided to FY99 KHC recipients. As seen below in Figure 1, expenditures on "Drugs" and "Immunosuppressive Drugs (ISDs)" used in the treatment of ESRD are the largest expenditure among KHC recipients, comprising almost $12 million of the KHC client services budget. As of December 31, 1999, client services expenditures were approximately $16.4 million and are expected to be nearly $16.5 million after all FY99 claims have been processed. Because of the increase in program growth, the amount needed to reimburse allowable claims exceeded the amount initially budgeted in FY99. The Texas Department of Health provided additional funding which allowed KHC to continue providing payments for FY99 claims.

Table 2: Fiscal Year 1999 Client Services Expenditures

Medical Services	$	1,282,419
Immunosuppressive Drugs (ISDs)	$	3,200,656
Drugs	$	8,793,520
Travel	$	3,126,860
Total Client Services Expenditures as of 12/31/99	**$**	**16,403,455**

Figure 1: Client Services Expenditures, FY95-99



Expenditures reported in Table __ and Figure __ are not complete due to KHC's 95-day claim filing deadline.

Client Services Expenditures and Unduplicated Recipients

Table 3 and figure 2 (page 8) illustrate the expansive growth of the ESRD population served by KHC and compares that growth to the total appropriation for KHC and the amount expended on client services (CS) over a fifteen year period. As the number of people who are eligible for the program has increased, the "expenditure per recipient" has decreased. In the mid 1980's, the average expenditure per recipient was approximately $2000 per fiscal year, while in the mid-to-late 90's, that figure dropped to around $1000 per fiscal year.

As seen in Figure 2 on page 8, the number of people who are eligible for the KHC program has increased during the past fifteen years. In FY85, KHC served over 5,000 unduplicated recipients and in FY99, that number exceeded 17,000.

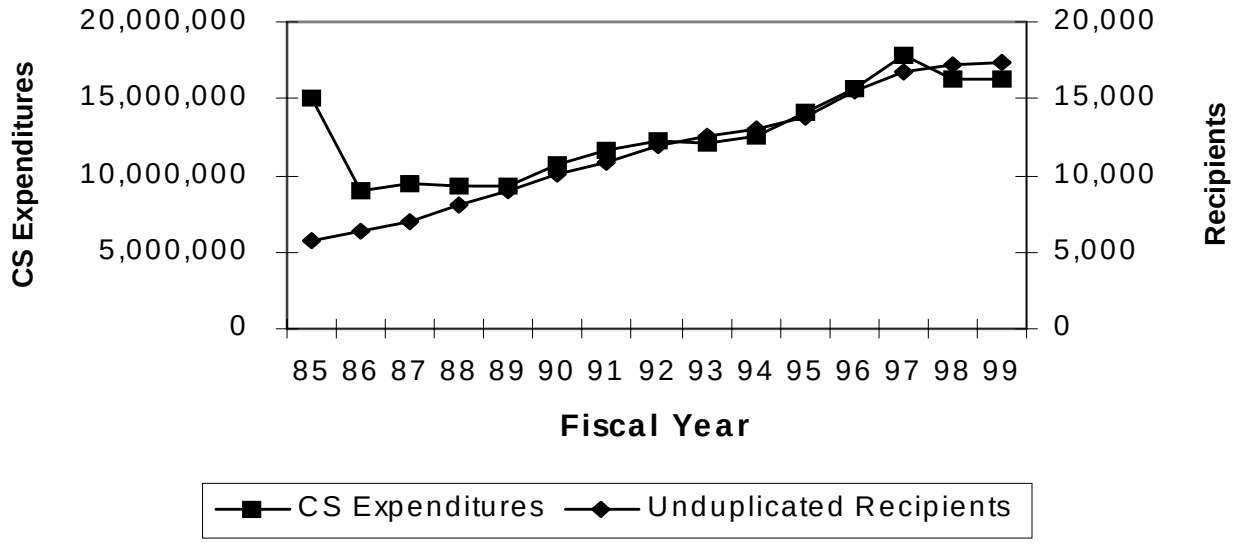
When examining client services expenditures over the past fifteen years, it is evident that funding has not kept pace at a rate adequate to continue providing the same level of services. As a result, the expenditure per recipient has steadily decreased since FY91, with the exception of FY97 and FY98, when KHC processed travel benefits for KHC recipients who were also eligible for Medicaid travel (see Table 3 below).

Table 3: Client Services Expenditures and Unduplicated Recipients

Fiscal Year	KHC Total Budget	Client Services Expenditures	Unduplicated Recipients	Expenditure per Recipient
85	$ 15,737,248	$ 15,022,623	5,774	$ 2,602
86	$ 9,548,438	$ 8,997,391	6,377	$ 1,411
87	$ 9,969,953	$ 9,436,721	7,044	$ 1,340
88	$ 9,973,442	$ 9,300,774	7,987	$ 1,164
89	$ 9,986,208	$ 9,374,638	9,034	$ 1,038
90	$ 11,321,450	$ 10,631,499	10,016	$ 1,061
91	$ 12,349,838	$ 11,608,723	10,928	$ 1,062
92	$ 13,165,309	$ 12,251,598	11,966	$ 1,024
93	$ 13,055,598	$ 12,022,519	12,547	$ 958
94	$ 13,588,910	$ 12,561,567	12,964	$ 969
95	$ 15,353,705	$ 14,104,412	13,726	$ 1,028
96	$ 17,240,127	$ 15,688,022	15,442	$ 1,016
97	$ 18,940,127	$ 17,758,278	16,737	$ 1,061
98	$ 18,240,127	$ 16,250,320	17,222	$ 944
99	$ 18,850,152	$ 16,403,455	17,452	$ 940

Expenditures and Unduplicated Recipients as of December 31, 1999. These numbers may be higher at the end of FY99 due to the 95-day claim filing deadline.

Figure 2: Program Growth FY85-99



Client Services Expenditures by Primary Diagnosis

Table 4 reports the distribution of client services expenditures by primary diagnosis and includes the percent of total expenditures by primary diagnosis for FY99. KHC recipients with a primary diagnosis of diabetes constituted the largest portion of FY99 client services expenditures ($6.9 million).

Of the remaining FY99 client services expenditures, recipients with a primary diagnosis of hypertension and glomerulonephritis comprised the greatest portion of expenditures, at $4.1 million and $2.8 million, respectively.

There are variant factors that influence the costs and expenditures for KHC recipients according to primary diagnoses. These factors include the costs of medications that are associated with certain primary diagnoses, the level of co-morbid conditions

Table 4: Client Services Exenditures by Primary Diagnosis

Diagnosis	Expenditures	% Total Expenditures
Diabetes	$ 6,919,356	42.4%
Hypertension	$ 4,166,297	25.5%
Glomerulonephritis	$ 2,841,514	17.4%
Congenital Anomalies	$ 712,466	4.4%
Connective Tissue Disease	$ 368,220	2.3%
Blood Diseases	$ 9,930	0.1%
HIV/AIDS	$ 20,015	0.1%
Urinary System Disease	$ 471,048	2.9%
Metabolic Diseases	$ 25,436	0.2%
Malignant Neoplasm	$ 55,299	0.3%
Etiology Unknown	$ 601,088	3.7%
Other	$ 119,003	0.7%
Total	**$ 16,309,672**	**100%**

Client Services Expenditures as of October 31, 1999

within the population, and little or no third-party coverage for medications and medical expenses.

Client Services Expenditures by Treatment Status

Table 5 reports the distribution of client services expenditures by treatment status and includes the percent of total expenditures by treatment status for FY99. Although considerable variation exists in spending among treatment modalities, expenditures for in-center hemodialysis recipients continue to be the greatest, comprising almost 60% of the FY99 client services budget. In FY99, $9.6 million of the client services budget was expended on those recipients utilizing this treatment modality.

Although in-center hemodialysis continues to be the predominant treatment modality among KHC recipients, expenditures for cadaveric transplant recipients represented a considerable portion of FY99 client services budget (27.6%). In FY99, there was a 2.7% increase in expenditures for this group of recipients over FY98 recipients who received cadaveric transplants.

Table 5: Client Services Expenditures by Treatment Status

	Treatment Status	Expenditures	% Total Expenditures
In-Center	Hemodialysis	$ 9,682,262	59.4%
	Peritoneal Dialysis	$ 0	0%
	Self Hemodialysis	$ 31,655	0.2%
In-Home	CAPD	$ 478,679	2.9%
	CCPD	$ 281,773	1.7%
	Hemodialysis	$ 17,270	0.1%
Transplant	Living Donor	$ 972,957	6.0%
	Cadaveric Donor	$ 4,495,133	27.6%
***Other**		$ 349,943	<2.2%
	Total	**$ 16,309,672**	**100%**

*" Other" includes expenditures for recipients who received benefits in FY99, but died, regained function, or voluntarily stopped treatment during the fiscal year being reported.

Client Services Expenditures as of October 31, 1999

Client Services Expenditures by Age Group

Table 6 reports the distribution of client services expenditures by age group and includes the percent of total expenditures by age for FY99. Among all age groups, the largest amount expended was on those recipients in the 45-54 age group ($4.1 million). The amount expended on recipients in the 55-64 age group followed closely at $3.7 million. Together, these two age groups comprised 48.4% of the FY99 client services budget. In FY98, the largest amount expended by age group was also for those recipients within the 45-54 and 55-64 age groupings.

The higher expenditures in these age groups may be due to the number and severity of co-morbid conditions in these age groups and the costs of reimbursable medicatons associated with various primary diagnoses in these age groups.

Table 6: Client Services Expenditures by Age Group

Age Group	Expenditures	% Total Expenditures
20 & Under	$ 51,323	0.3%
21-34	$ 1,159,943	7.1%
35-44	$ 2,653,213	16.3%
45-54	$ 4,121,010	25.3%
55-64	$ 3,764,197	23.1%
65-74	$ 3,254,974	20.0%
75+	$ 1,305,012	8.0%
Total	**$ 16,309,672**	**100%**

Client Services Expenditures as of October 31, 1999

Administrative Costs

Table 7 reports the distribution of administrative costs for FY85-99. Administrative costs as a percentage of KHC's budget continue to be less than 10% of the total budget. In FY99, administrative costs comprised 8.9% of KHC's total budget. The increase in administrative expenses during FY99 is primarily due to automation technology for claims and application processing functions.

Table 7: Administrative Costs as of 10/31/99

Fiscal Year	Total Budget	Administrative Costs	% Total Budget
85	$ 15,737,248	$ 714,625	4.5%
86	$ 9,548,438	$ 551,047	5.8%
87	$ 9,969,953	$ 533,232	5.3%
88	$ 9,973,442	$ 672,668	6.7%
89	$ 9,986,208	$ 611,570	6.1%
90	$ 11,321,450	$ 689,951	6.1%
91	$ 12,349,838	$ 741,115	6.0%
92	$ 13,165,309	$ 913,711	6.9%
93	$ 13,055,598	$ 1,033,079	7.9%
94	$ 13,588,910	$ 1,027,343	7.6%
95	$ 15,353,705	$ 1,249,293	8.1%
96	$ 17,240,127	$ 1,273,075	7.4%
97	$ 18,940,127	$ 1,464,005	7.7%
98	$ 18,240,127	$ 1,549,040	8.5%
99	$ 18,850,152	$ 1,675,807	8.9%

Table 8: Administrative Expense Detail as of 10/31/99

Expenses	Total Expended as of 10/31/99	% Administrative Expenditures	% Total Budget
Salaries	$ 1,223,280	73.1%	6.5%
Travel	$ 5,120	0.3%	0.0%
Equipment	$ 61,909	3.6%	0.3%
Other Operating Expenses	$ 385,492	23.0%	2.1%
Total	**$ 1,675,801**	**100%**	**8.9%**